

Pelvic Floor Bother Questionnaire

Name:

Date:

Instructions: The following is a questionnaire about your pelvic health. All information is strictly confidential. Please mark (X) in the box that best describes your symptoms in the last month.

<p>1. Do you experience urine leakage (incontinence) related to physical activity, such as coughing, sneezing, laughing, lifting or changing positions? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how much does it bother you? Not at all <input type="checkbox"/> Only a little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> A moderate amount <input type="checkbox"/> A lot <input type="checkbox"/></p>
<p>2. Do you experience frequent urination (needing to urinate more than usual, including the need to get up two or more times during the night because of a need to urinate?) Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how much does it bother you? Not at all <input type="checkbox"/> Only a little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> A moderate amount <input type="checkbox"/> A lot <input type="checkbox"/></p>
<p>3. Do you experience an abnormally strong feeling of urgency to urinate (sudden, compelling urge to void)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how much does it bother you? Not at all <input type="checkbox"/> Only a little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> A moderate amount <input type="checkbox"/> A lot <input type="checkbox"/></p>
<p>4. Do you experience urine leakage associated with the feeling of urgency (involuntary loss of urine occurring while suddenly having a strong urge to urinate)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how much does it bother you? Not at all <input type="checkbox"/> Only a little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> A moderate amount <input type="checkbox"/> A lot <input type="checkbox"/></p>
<p>5. Do you experience difficulty or discomfort in passing your urine? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how much does it bother you? Not at all <input type="checkbox"/> Only a little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> A moderate amount <input type="checkbox"/> A lot <input type="checkbox"/></p>
<p>6. If female: Do you experience the feeling of a bulge in the vagina (either the bladder, uterus, vagina or rectum)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how much does it bother you? Not at all <input type="checkbox"/> Only a little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> A moderate amount <input type="checkbox"/> A lot <input type="checkbox"/></p>
<p>7. Do you experience difficulty in emptying your bowels, such as straining? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how much does it bother you? Not at all <input type="checkbox"/> Only a little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> A moderate amount <input type="checkbox"/> A lot <input type="checkbox"/></p>
<p>8. Do you experience accidental leakage of faecal matter or gas? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how much does it bother you? Not at all <input type="checkbox"/> Only a little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> A moderate amount <input type="checkbox"/> A lot <input type="checkbox"/></p>
<p>9. Are you sexually active? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, does pain or discomfort curtail your ability to enjoy sex? Not at all <input type="checkbox"/> Only a little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> A moderate amount <input type="checkbox"/> A lot <input type="checkbox"/></p>